General

Guideline Title

2013 UK national guideline for consultations requiring sexual history taking.

Bibliographic Source(s)

Clinical Effectiveness Group. 2013 UK national guideline for consultations requiring sexual history taking. London (UK): British Association for Sexual Health and HIV (BASHH); 2013. 29 p. [72 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: French P, Sexual History-Taking Working Party, Clinical Effectiveness Group of the British Association for Sexual Health and HIV. BASHH 2006 national guidelines--consultations requiring sexual history-taking. Int J STD AIDS. 2007 Jan;18(1):17-22.

Recommendations

Major Recommendations

Levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Confidentiality

The Environment for Sexual History Taking

A welcoming, comfortable, confidential physical environment is likely to encourage openness and candour when discussing sensitive issues, such as sexual behaviour. To facilitate this, the following measures should be adopted:

- Services may find that clearly displaying literature that stresses confidentiality of the clinic and the non-judgemental nature of assessment improves the consultation.
- Clinic administration procedures (storage/visibility of clinic files and clinic lists, etc.) should be designed to ensure that confidentiality is maintained between patients.
- Clinics should decide on the most appropriate way of calling patients for consultations such as calling by first name, full name, or clinic number. Care should be taken to confirm that patient identification is correct.
- Consultations should take place in private settings and in sound-proofed room.
- Students and observers should be present only with the patient's consent, and the wishes of the patient should be respected if the presence of a student or observer is declined. However, the patient should be offered a chaperone for any intimate examination.

- Requests for clinician gender on the basis of culture, religion, or personal preference should be accommodated where possible and pathways to other services should be in place to support patients whose preferences cannot be accommodated.

Recommendation: Sexual history taking should take place in a confidential, private environment. (IV, C)

Recommendation: All clinics should have a confidentiality policy that should be displayed in the waiting area or otherwise made available to patients. (IV, C)

Recommendation: All patients should be offered a chaperone for any intimate examination in accordance with General Medical Council (GMC) guidance. (IV, C)

Recommendation: All patients should be offered a clinician of their preferred gender where possible. (IV, C)

Management of Sexual Contacts

The utmost care should be taken to preserve the confidentiality of patients and their sexual contacts during the consultation. This can be difficult in certain situations; for example, where a patient attends as a contact of an infection but does not know the reason for their attendance. The index patient must not be identified. The clinician must not confirm the identity of the index patient, even if raised by the patient, or reveal any details about their attendance (or non-attendance) or clinical condition. Care should also be taken to avoid having third-party information in a form that might be easily viewable on an electronic patient record in case a patient might see this on the computer screen.

Communication

Clinic Access and External Communication/Advertising

Although many patients who are referred to or refer themselves to sexual health/UK genitourinary medicine (GUM) clinics will expect to be asked sensitive questions regarding their sexual behaviour, this may not always be the case.

Clinic advertising, including the use of Web sites and clinic leaflets displayed elsewhere (e.g., general practitioner [GP] surgeries, contraceptive clinics, schools, colleges, etc.), should explain the role of the clinic and what should be expected during a consultation. This may improve the acceptability of asking questions which may otherwise be perceived as being intrusive.

Recommendation: Clinic literature/advertising leaflets should include sections regarding the need to take an appropriate sexual history. (IV, C)

Communication Skills

The ability to communicate effectively is required of all clinicians and may be important in improving health outcomes. The initial contact with a patient can be particularly important for obtaining an accurate sexual history and particular attention should be paid to:

- The initial greeting to the patient
- Maintaining eye contact (if culturally acceptable) and using appropriate body language
- Initiating a consultation with open questions[a] followed by exploration of initial concerns and more closed questions as the consultation continues
- Explaining the rationale for some of the questions asked
- Consider the use of sexually explicit language within the sexual history consultations and use language that is clear, understandable, and with which both clinician and patient are comfortable
- Awareness of the signs of anxiety and distress from the patient
- Recognizing non-verbal cues from the patient

[a]Examples of open questions include 'how can I help you today?' or 'what brings you here today?'.

Particular issues that need to be covered in training clinicians in sexual history taking include addressing attitudinal issues of the clinician to sexual behaviour and specific knowledge about the range of sexual consultations that can be undertaken. Although there are well-recognised models of best practice in communication skills training, assessment of the quality of communication skills is complex. A variety of different mechanisms for assessing communication skills have been proposed including patient questionnaires and direct or video-recorded consultation with patients or actors.

Recommendation: Assessment of clinician communication skills should form part of the assessment of service quality. (IV, C)

Communication Difficulties

All sexual health clinics should have policies in place to address the communication needs of specific patient groups, including patients whose first language is not English, people with hearing or learning difficulties, and people who cannot read. Sign language interpreters; foreign language interpreters; access to telephone interpretation services; use of communication aids, including Web sites; working with local support organisations; and dedicated clinic times for patients with communication problems, are all strategies that may need to be adopted.

Recommendation: All sexual health clinics should have policies in place to address the needs of patients with whom there are communication problems, including illiteracy. (IV, C)

Components of a Sexual History

The appropriate detail of the sexual history will vary between services but should allow:

- A careful assessment of symptoms to guide the examination and testing
- An exposure history to identify which sites need to be sampled and the sexually transmitted infections (STIs) to which the patient may be at risk
- An assessment of contraception use and risk of pregnancy
- Assessment of other sexual health issues (also allowing a discussion of psychosexual problems)
- Assessing human immunodeficiency virus (HIV), hepatitis B and C risk for both testing and prevention
- Assessment of risk behaviours, which will then facilitate health promotion activity including partner notification and sexual health promotion

A summary of suggested sexual histories in different testing scenarios is given in Tables 1-4 in the original guideline document.

Reasons for Attendance

It is best to start the sexual history with less intrusive questions regarding presenting concerns and symptoms before asking more sensitive questions regarding sexual behaviour. After the reason for attendance has been identified, the clinician should ask closed questions to identify specific GU symptoms. All clinicians will ask further questions regarding the duration and nature of any reported symptoms. Some patients may report that a partner has an STI and it is important to clarify the nature of the infection and contact as accurately as possible.

Symptom Review

It is uncertain whether a symptom review in patients not reporting symptoms is useful. However, many GUM clinicians ask about specific genital symptoms in case this reveals overlooked or ignored problems. Many clinicians would routinely ask women presenting to GUM clinics questions relating to the following symptoms:

- Unusual vaginal discharge
- Vulval skin problems
- Lower abdominal pain/deep dyspareunia
- Dysuria
- Unusual vaginal bleeding, including post-coital and inter-menstrual bleeding

Many clinicians would routinely ask men presenting to GUM clinics questions relating to the following symptoms:

- Urethral discharge
- Dysuria
- Genital skin problems
- Testicular discomfort or swelling
- Peri-anal/anal symptoms (in men who have sex with men [MSM])

Sexual History

The more detailed parts of the sexual history outlined below may be identified during the initial discussion with the patient. They will, however, more often be dealt with while asking more 'closed' questions later in the consultation.

Services primarily undertaking STI screening may undertake a brief core sexual history to establish whether someone is at any risk of STIs and take a more detailed history if the STI screen is positive.

Using 'bridging' questions, which link general lifestyle questions to sexual history questions or 'universal' questions (questions which are explicitly asked of all patients), may also help when introducing sensitive questions. The need to ask important questions regarding risk taking (such as same sex partners and injecting drug use), which some patients may find offensive, should be clearly explained to all patients.

It is important to ascertain the type of sexual contact/sites of exposure in both MSM and heterosexual men and women in order to be able to identify which sites need to be sampled. In women who report oral or anal sex, up to 25% of chlamydia or 35% gonorrhoea infection would be missed if the pharynx or rectum were not sampled, as infection may be found in these extra-genital sites only. In addition, a similar proportion of infection is present in both genital and extra-genital sites. Azithromycin is reported to be as little as 80% effective in eradicating extra-genital chlamydia infection with doxycycline being much more effective. Therefore, if extra-genital swabs are not taken from a person at risk, the infection may go unrecognised and untreated or the patient may be given inadequate antibiotic therapy. This would leave the patient still infected and acting as an infection source to partners as well as potentially being at risk from complications of the infection. A history of the types (sites) of sexual contact is also recommended in the International Union against Sexually Transmitted Infections (IUSTI) European guidelines for the organisation of a consultation for STIs, 2012.

Last Sexual Contact (LSC)

All individuals being assessed for risk of STIs should be asked about:

- The gender of partner(s)
  Rationale: To identify MSM in order to offer rectal and pharyngeal samples, undertake hepatitis screening and vaccination
- The type of sexual contact/sites of exposure (oral, vaginal, anal) (II, A)
  Rationale: To identify which sites need to be sampled
- Condom use/barrier use (and whether properly used)
  Rationale: Facilitation of condom promotion and risk assessment
- The relationship with the partner (live-in, regular, casual partner, etc.), duration of the relationship and whether the partner could be contacted
  Rationale: To facilitate partner notification
- The time interval since the last sexual contact
  Rationale: To inform the patient of any need for repeat testing if still inside 'window' periods for infection detection and to help in assessing the need for emergency contraception or post-exposure prophylaxis for HIV infection
- Any symptoms or any risk factors for blood-borne viruses (BBV) in the partner including known or suspected STIs, injecting drug use, previous homosexual sex (for male partners) and any other risk of sexual infection
  Rationale: To identify STI or BBV diagnosis, or symptoms suggestive of an STI, in partners

Previous Sexual Partner, if Less Than Three Months Previously (Before Partner of LSC, Last Partner Change)

All individuals should be asked about the:

- Gender of partner(s)
- Sites of exposure
- Use of barrier methods
- Relationship to partner (as for LSC)
- Symptoms or high-risk behaviour of this partner
  Rationale: This is the same rationale as for LSC.

Look-back Interval for Recording Information About Partners

- As a minimum, the sexual history should include a record of the number of partners within the previous three months and the last two partners if both were within the last three months. Taking a three-month risk history would identify risk behaviour not covered by a negative syphilis and third generation HIV antibody test on the day of the consultation. If no partners are reported during this time, the last time the patient had sexual contact should be noted.
- If the patient is known, or suspected of having a particular STI, the look-back interval(s) in the British Association for Sexual Health and HIV (BASHH) Statement on partner notification for sexually transmissible infections should be used.
- All patients who report no unprotected penetrative oral, vaginal or anal sex during this period should be asked the last time these events took place.
- All men should be asked if they have ever had sex with another man.
  Rationale: To establish which STIs the patient may be at risk of, to offer relevant vaccinations and to inform partner notification

Other Components of the History

Previous STIs

Recommendation: All individuals should be asked about a history of STIs and HIV. (IV, C)

- The diagnosis and approximate date of diagnosis should be recorded. All patients should be asked about a history of previous STIs (including HIV).
- Patients with a history of previous syphilis should have the date of diagnosis, stage of syphilis, treatment given, and clinic of treatment recorded.
  Rationale: To allow the interpretation of positive syphilis serology in patients with a previous history of syphilis

- Past medical and surgical history
  Rationale: To identify conditions that may be associated with or influence the management of STIs

- Drug history and history of allergies. All patients should have a history of current medication taken, including over-the-counter remedies, and be asked for history of previous allergies, particularly to antibiotics
  Rationale: To identify medication that may interfere with sexual function, to identify potential drug interactions and if drugs cannot be given safely

- Alcohol and recreational drug history. May be indicated particularly in cases where disinhibition may be a factor in risk taking behaviour and in young people taking risk
  Rationale: Alcohol and recreational drugs are a major factor in sexual risk taking. Screening tools such as FAST and Alcohol Use Disorders Identification Test (AUDIT) are quick and simple to do. Some services will screen and undertake Alcohol Brief Interventions.

- For women born after 1995, a human papillomavirus (HPV) vaccination history
  Rationale: To facilitate access to vaccination of those eligible if not started or not completed

Contraceptive and Reproductive Health History

Increasingly, sexual health services are provided as integrated STI/contraception clinics. The contraception and reproductive health history may therefore vary according to whether the service primarily has an STI testing and treatment focus, or is providing an integrated service.

Recommendation: All women should be asked about the following (IV, C):

- Contraceptive use and compliance
- Last menstrual period and menstrual pattern
  Rationale:
  - To identify pregnancy or pregnancy risk
  - To avoid drugs contraindicated in pregnancy
  - To provide post-coital contraception if indicated
  - To give advice regarding contraception if necessary
  - To exclude contraceptive methods as a cause of irregular bleeding
  - To avoid prescribing enzyme inducing drugs in conjunction with low dose hormonal contraceptive methods (except for injectables)
- Previous pregnancies including outcomes and complications
  Rationale: Part of the assessment of reproductive and sexual health, including any impact on the current presentation and the identification of children who may be affected by STIs

- When the last cervical cytology was taken (if aged 25 years or over in England, Northern Ireland, and Republic of Ireland or 20 years or over in Scotland and Wales), the result, and if ever abnormal (IV, C).
  Rationale: To determine whether to recommend cervical cytology

The Integrated Contraception and Sexual Health Service

In the integrated contraception and sexual health service the history will generally be more detailed in the following areas:

For female patients:

- Identify unmet contraceptive need, including the need for emergency contraception and eligibility for different contraceptive methods. The

UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) shows areas that should be reviewed with regard to identifying risks associated with hormonal contraceptive methods.
Rationale: Review of contraceptive need provides opportunities for information giving, motivational interviewing, and provision of contraception

- Current contraceptive use, any difficulties with the current method, the correct use of, and satisfaction with the method used (including condoms and natural methods), and the need for on-going supplies
  Rationale: Review of current contraception may provide opportunities to improve concordance and satisfaction, and unscheduled vaginal bleeding or pelvic pain may be a side-effect of contraception. The Faculty of Sexual and Reproductive Healthcare guidance deals with unscheduled vaginal bleeding in women using hormonal contraception, including points to cover in the clinical history, as well as management.

- Identifying any unintended pregnancy risk and the need for pregnancy testing
  Rationale: Recognising unwanted pregnancy allows for the provision of support and improves access to termination of pregnancy services.

- History of abnormal vaginal bleeding
  Rationale: Unusual vaginal bleeding may be due to cervical pathology and may prompt the offer of cervical examination and need for urgent colposcopy clinic referral.

- Menstrual pattern, including any change in pattern
  Rationale: Ascertaining the menstrual pattern is important for determining pregnancy risk, decision-making for European Commission (EC) provision, assessment of pelvic pain, and in supporting the diagnosis and referral of women with polycystic ovarian syndrome, other gynecological disease, and the post-menopause state where necessary.

- Mood change associated with the menstrual cycle
  Rationale: Provision of support and access to referral pathways for management of possible premenstrual syndromes

- Family history
  Rationale: To determine eligibility and contraindication for contraception according to UKMEC

- Smoking history
  Rationale: Modifiable risk factor for cervical cancer and alters UKMEC status of combined hormonal contraception

- HPV vaccination history
  Rationale: To facilitate access to vaccination of those eligible if not started or not completed

For male patients:

- Discussion with male patients about contraception, including contraceptive use by female partners
  Rationale: Provides opportunities for information giving, including male methods of contraception, motivational interviewing, and may facilitate the use of services by female partners

- Identification of unrecognized lower urinary tract symptoms in men, particularly men aged >40 years. These include symptoms related to storage, voiding, and post-micturition
  Rationale: Recognition of these symptoms may aid in the assessment of other symptoms in men presenting to sexual health clinics. This may lead to detection of disease including diabetes mellitus, benign prostatic enlargement and prostatic cancer, and provide opportunities for information giving, support, and access to referral pathways. National Institute for Health and Clinical Excellence (NICE) guidance provides the areas to cover in the clinical history, as well as management.

Female and male patients:

- Identification of unmet need with regard to difficulties with sexual performance and satisfaction. Presentation related to psychosexual problems are common in women and men in sexual health settings. In men, erectile dysfunction is associated with increased acquisition of STIs and non-use of condoms
  Rationale: Provides opportunities for information giving, support and provision of referral pathways

- Recognition of gender-based violence (GBV) or intimate partner violence (IPV). GBV/IPV is associated with sexual assault, STIs, and unintended pregnancy as well as other risk factors
  Rationale: Provision of support and access to referral pathways. The Department of Health has produced a toolkit to help practitioners

manage IPV. NICE is producing Public Health guidance on preventing and reducing IPV. Although there are no validated screening questions for IPV in sexual health settings, the brief questions in the pilot draft produced by the Camden Multi Agency Domestic Violence Forum are widely recommended for use. Routine enquiry about current and historic gender-based violence aims to detect men and women who may be at risk of further ongoing violence and alerts practitioners to consider their safety. This is now mandatory in sexual health services in Scotland.

Risk Assessment for Blood-borne Viruses

Recommendation: All individuals should be asked about the following (IV, C):

- Current or past history of history of injecting drug misuse; sharing of needles, syringes, or other drug preparation, and injecting equipment ('works'). To also include discussion of injecting drug misuse in sexual partners (IV, C)
  Rationale: To identify the need for hepatitis B, hepatitis C and HIV testing and hepatitis B vaccination
- Sex with a partner from or in a country with a high HIV prevalence
  Rationale: To identify sexual partners at higher risk of HIV (IV, C)
- HIV testing history
  Rationale: To determine whether HIV testing is necessary
- Men should be asked if they have ever had sexual contact with another man and women asked about previous bisexual male partners
  Rationale: To identify the need for hepatitis B and HIV testing and hepatitis A and B vaccination
- Hepatitis B risk (including patient's country of birth, sex with sex workers, partners from or in high prevalence countries, MSM, and injecting drug users) and hepatitis B vaccination history (IV, C)
  Rationale: Identification requires serological testing of hepatitis B and vaccination.

The following risks may be also asked about, where appropriate:

- Men and women may be asked whether they have ever exchanged money in return for sex (IV, C)
  Rationale: To allow appropriate health promotion and hepatitis B testing and vaccination
- Other risks: non-use of condoms associated with erectile dysfunction, repeated condom breakage or slippage, participation in group sex events, use of alcohol and non-injecting drug use, use of social networking Web sites to find sexual partners, use of high risk venues, receptive fisting, traumatic sexual practice, and use of sex toys
  Rationale: To identify specific behaviors, associated with increased STI acquisition, that may provide opportunities for safer sex and substance use information-giving and support, and direct the offer of tests
- Medical treatment/tattooing where sterility cannot be guaranteed
  Rationale: To establish the need to test for nosocomial BBV acquisition

Closing the Sexual History

Recommendation: After the sexual history is completed, the clinician should (IV, C):

- Check with the patient that they have no other concerns that have not yet been discussed. These may include psychosocial concerns, issues about 'coming out', safety in relationships, information about STI transmission
- Explain the need for, and nature of, a clinical examination and tests
- Give the patient the option of a chaperone for the examination
- The method of communicating results to the patient should be agreed

Documentation

General Principles

Sexual health clinics have historically maintained their own record sets and record systems. That does not release them from following local and national guidance and law about records retention, data protection, and subject access requests. Particular care is needed in sexual health services regarding the recording (and thus potential disclosure) of third-party information (where a person who is not the patient discloses something about the patient). Services that make use of general health records (e.g., as part of a hospital outpatient service or electronic system) need to consider who may access that record and ensure patients are informed about confidentiality arrangements.

Recommendation: It is recommended that (IV, C):

- The record keeping of a sexual history should be in keeping with national standards of practice.
- Services should agree minimum data sets taking into account local and national health priorities and reporting requirements. Services should audit record-keeping for completeness against this.
- Sexual health records should be processed and stored in accordance with local and national guidance and law. Third-party data should be clearly indicated.

The Use of Standard History Proformas

Many services record the sexual history on proformas with a locally-agreed dataset. These may:

- Assist timely record keeping
- Make history taking more systematic
- Reduce the chance of omitting important pieces of information
- Facilitate audit

Services should consider the range of data items in the light of their local and national health priorities and needs. For example in Scotland, routine enquiry about gender-based violence was mandated in sexual health services in 2008 and a national minimum data set for all sexual health services was agreed in October 2011 to replace the STISS coding system (see Appendix 2 in the original guideline document).

Electronic Patient Records (EPR)

Many services now use clinical information systems. These range from simple demographic registers to fully-fledged bespoke sexual health paperless electronic record systems (see Appendix 3 in the original guideline document). Services implementing electronic record systems need to ensure staff are trained in their use and are aware of their responsibilities for data protection. The Department of Health (DH)/Royal College of General Practitioners (RCGP)/British Medical Association (BMA) produced guidance for paperless working for GPs in 2011, with chapters on data accuracy and moving to paperless practice, including tips on how to consult while using a computer. This is relevant to sexual health clinic settings. There are also several publications now that demonstrate the advantages of EPR in the sexual health setting.

Computer-assisted Interviews

Some services now offer computer-assisted self-interviews (CASI) or computer-assisted personal-interviews (CAPI) to replace some of the routine 'pen and paper' face-to-face clinical interview. Evidence shows a CASI approach to be acceptable in a sexual health setting with similar consultation times and few patients declining to answer risk questions. Although CASI may yield additional disclosures in sensitive question areas, some evidence shows staff may not act on this information and that overall STI or HIV detection rates may not improve.

Specific Circumstances

Seeing Patients Who Are Under the Age of 16 Years

There is a specific national guideline for children and young people. The following is a brief description of some of the important issues.

Competency

Recommendation: All patients less than 16 years of age should have their competency to consent to history taking, examination and treatment assessed and this assessment should be documented in the clinical notes. (IV, C).

Safeguarding Children

Where there are any concerns regarding a child's safety, there should always be serious consideration given to liaison with the local safeguarding children team.

Answers to the following additional questions may flag up the need for further assessment and liaison with the local safeguarding children team:

- Whether parents/carers are aware of the child's sexual activity
- Whether parents/carers are aware of the child's attendance at the clinic
- Whether the child has ever had non-consensual sexual contact
- Age of sexual partner(s)
- Vulnerability (e.g., self-harm, psychiatric illness, drug or alcohol misuse, where there is an imbalance of power, e.g., youth workers/teachers, or grooming is likely)

Where children under the age of 13 years report sexual activity, this should be discussed with a senior colleague and there is an expectation that this will be discussed in confidence, with the local child protection lead. Reporting to social service and the police may be indicated but is not mandatory. In Scotland, the guidance is that 'practitioners should automatically share child protection concerns' for children who are having or have ever had sex when aged under 13.

Taking a Sexual History in the Outreach Setting

Outreach clinics, either run by GUM clinics or which have been devolved to other providers, bring sexual health services out of traditional settings.

Recommendation: The following factors should be considered when taking a sexual history in an outreach clinic (IV, C):

- The structure of the sexual history taken should be adapted to the needs of the community or client group being served in order to be inclusive and to promote sexual well-being regardless of culture, gender, age, sexuality and sexual lifestyle. For example, more focused discussion of contraception in areas of high teenage pregnancy rates or the additional needs of MSM.
- All services should be provided in a comfortable environment that supports the patients' confidentiality and dignity.
- Specific consideration should be given to security measures for the protection of staff working in remote sites or in out-of-hours services.
- Chaperoning for the medical interview and examination should be available and offered to all patients.
- Clinical governance arrangements for outreach clinics should be robustly maintained for both National Health Service (NHS) and non-NHS providers.
    - The use of a proforma for history taking is recommended and its correct use should be audited regularly.
    - The scope of practice of the service should be clearly defined and referral pathways established for patients presenting with symptoms beyond this scope; for example: ectopic pregnancy; sexual assault; HIV post-exposure prophylaxis.
    - Information governance arrangements must be clearly defined, as the secure transfer of information is essential for good care. Protocols should be in place to guide the secure storage, transfer and relevant sharing of information. The use of an electronic patient record is recommended as this is more secure and minimizes the transfer of paper records.

Definitions:

Levels of Evidence

Ia: Evidence obtained from meta-analysis of randomised controlled trials

Ib: Evidence obtained from at least one randomised controlled trial

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendations

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Sexual health

Guideline Category

Diagnosis

Evaluation

Risk Assessment

Clinical Specialty

Family Practice

Infectious Diseases

Obstetrics and Gynecology

Urology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To provide guidance for best practice in consultations requiring sexual history taking
- To help improve the sexual health of individuals attending UK genitourinary medicine (GUM) and integrated sexual health clinics by encouraging high standards of sexual risk assessment
- To offer recommendations on best practice regarding sexual history for both men and women including adolescent patients

Target Population

Men and women, including adolescents

Interventions and Practices Considered

1. Maintenance of patient confidentiality, including consideration of the physical environment for history taking

2. Ensuring a welcoming, comfortable, confidential environment, including offering chaperones or gender-preferred clinicians
3. Management of sexual contacts
4. Communication strategies, including use of clinical literature/advertising leaflets, Web sites, use of good communication skills, and policies to address the needs of specific patient groups
5. Appropriate components of sexual history taking, including:
    - Reasons for attendance
    - Symptom review
    - Sexual history
    - Previous sexually transmitted infections (STIs)
    - Contraceptive and reproductive health history
    - Risk assessment for blood-borne viruses
6. Record keeping in keeping with the recommended national standards of practice
7. Special considerations for patients less than 16 years of age

Major Outcomes Considered

- Effectiveness of sexual history taking in patient diagnosis and risk assessment
- Comfort of patients undergoing sexual history taking
- Identifying unintended pregnancy risk and need for pregnancy testing
- Proportion of new/rebooked patients

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

A literature search was undertaken using the terms 'sexual history', 'sexual history-taking' and 'sexual risk assessment' on Medline and PubMed databases 2006-July 2012. In addition, sections on sexual history taking in relevant British Association for Sexual Health and HIV (BASHH) and other guidelines were reviewed for other references. Forward and backward searching from key references was also conducted.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Ia: Evidence obtained from meta-analysis of randomised controlled trials

Ib: Evidence obtained from at least one randomised controlled trial

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guideline development is undertaken by a multi-disciplinary writing committee with membership determined in a transparent manner. The chair is chosen by the Clinical Effectiveness Group (CEG). The CEG lead then discusses with the chair what suggestions they might have for members from other disciplines. The additional members of the group are then invited by the CEG. Writing committee membership includes relevant professional groups (for example genitourinary medicine physicians, nurses, health advisors, pharmacists, microbiologists and other professionals from allied specialities as appropriate) and when relevant this will involve working with the appropriate British Association for Sexual Health and HIV (BASHH) Special Interest Group (SIG) and the BASHH audit group.

Patients' views and preferences are sought and considered and the process documented. This may include patient representative involvement in the writing committee, information obtained from patient interview or surveys during the writing and/or piloting process, reviewing published work on patient experiences or involving patient associations. The chair of the writing group identifies an appropriate member such as the Health Advisor to get patient feedback on the guideline. BASHH is currently developing a public panel to assist with its work and in the future this group could be approached to assist in guideline development.

Recommendations are formulated with consideration of their health benefits, side effects and risks, with evidence presented in the guideline that these issues have been addressed. Each recommendation is linked to the supporting evidence with a list of relevant references.

Consideration is given to pragmatic and organisational issues relevant to the guideline. This is sought during and may emerge from the piloting of the guideline.

The authors consider the financial cost implications of recommendations made. Where disagreement arises within the writing committee with regard to recommendations the chair attempts to resolve these (for example by a voting system or formal consensus method). The process is documented and reported to the CEG editor. When this is not possible the CEG will review the evidence.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the

specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Prior to publication, the final draft of the guideline was placed on the British Association for Sexual Health and HIV (BASHH) Web site for a three month consultation period and copies were circulated to the Genitourinary Nurses Association (GUNA), the Society of Sexual Health Advisers (SSHA) chairs and the FSRH for comment and peer review. It was also reviewed by the BASHH Public Panel. This guideline was piloted before it was finally ratified.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Effective sexual history taking on which to base clinical decision-making
- Increased comfort level of patients undergoing sexual history taking

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- This guideline should apply to sexual history taking within UK Genitourinary Medicine (GUM)/Sexual Health settings. It is intended as a framework for sexual history taking and different settings will require the guideline to be adapted accordingly. It is likely that services in outreach settings and offering rapid access to screening will need to apply the components of this guideline appropriately to their level of service.
- Unlike other Clinical Effectiveness Group guidelines, this is not a tool for decision-making after establishing a diagnosis; rather, it describes best practice for establishing the facts on which clinical decision-making is based.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Group. 2013 UK national guideline for consultations requiring sexual history taking. London (UK): British Association for Sexual Health and HIV (BASHH); 2013. 29 p. [72 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2007 Jan (revised 2013)

Guideline Developer(s)

British Association for Sexual Health and HIV - Medical Specialty Society

Source(s) of Funding

This guideline was commissioned and edited by the Clinical Effectiveness Group of the British Association of Sexual Health and HIV (BASHH), without external funding being sought or obtained.

Guideline Committee

Clinical Effectiveness Group

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

None declared for all authors.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: French P, Sexual History-Taking Working Party, Clinical Effectiveness Group of the British Association for Sexual Health and HIV. BASHH 2006 national guidelines--consultations requiring sexual history-taking. Int J STD AIDS. 2007 Jan;18(1):17-22.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from British Association of Sexual Health and HIV Web Site .

Availability of Companion Documents

The following are available in the original guideline document :

- Auditable outcomes are available in Section 8.
- The Sandyford Minimum Data Set Flow Chart is available in Appendix 2.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on June 16, 2008. The information was verified by the guideline developer on August 13, 2008. This NGC summary was updated by ECRI Institute on October 1, 2013.

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